Pilot Program
Medical Billing Dispute Resolution

INSTRUCTIONS for REQUESTS for DISPUTE RESOLUTION

Only bills from medical providers in Contra Costa and San Bernardino Counties for medical services provided from April 1, 2000 through June 30, 2000 will be considered. Participation in this Pilot Program is voluntary. Both parties must agree to participate in the Dispute Resolution process in order for a recommendation to be made. Requests for dispute resolution must be made on the attached dispute resolution request form. All sections of the form must be completed; incomplete requests will not be processed. A separate request must be submitted for each separate bill that is disputed. Below are instructions for filling out the form:

1. Requestor: the individual or company making the request for Dispute resolution.

2. Respondent: the other party involved in the dispute. The Contact Person should be the individual most familiar with the billing dispute.

3. Type of dispute: check one or more boxes to indicate the type of dispute.

4. Employee: the injured worker for whom services have been provided.

5. Billing information: Fill in Total Amount Billed, Total Amount Paid, Total Amount Disputed, and Dates of Service.

6. Documentation: Check off each item attached. Items 1, 3 and 5 must be submitted. Submitting the other items listed is strongly recommended.

7. Please make note of the information under number 7.

8. Signature of the requestor is required.

Please mail completed request forms and all documentation to Division of Workers' Compensation, Northern California Regional Center, 175 Lennon Lane, Suite 200, Walnut Creek, CA 94958, Attn: Medical Billing Dispute Resolution Project. If you have questions regarding this project, please contact Suzanne Honor-Vangerov at (925) 952-4100 or e-mail shonor@hq.dir.ca.gov.

State of California
Department of Industrial Relations
Division of Workers' Compensation
P.O. Box 420603
San Francisco, CA 94142

Division of Workers' Compensation
Request for
Medical Billing Dispute Resolution

①**Requestor** (Please Type or Print)

Name

Address

City State Zip

Contact Person Telephone Number (with area code)

Federal Tax ID Number Professional License Number

Requestor is:
❒ PTP ❒ Consultant ❒ AME/QME ❒ Secondary Provider ❒ Claims Administrator
❒ Other:

②**Respondent** (Insurance Carrier or Health Care Provider)

Name

Address

City State Zip

Contact Person Telephone Number (with area code)

③**Type of Dispute**

❒ Incorrect CPT Code ❒ Incorrect Amount Paid ❒ Incorrect Ground Rule Application
❒ Inadequate Explanation of Review
❒ Other:

④**Employee Information**

Injured Workers' Full Name Date of Injury

Address

City State Zip

Telephone Number (with area code) Social Security Number

Nature of Injury

Employer

Address

City State Zip

Insurance Carrier

Address

City State Zip

Primary Treating Physician

Address

City State Zip

⑤**Billing Information:** This information is required.

$_____ Total Amount Billed

$_____ Total Amount Paid by Payor

$_____ Total Amount in Dispute

Dates of Service: From _____ To _____

From _____ To _____

From _____ To _____

⑥**Attach the Following Documentation:**

❒ (1) Copies of all disputed medical bills submitted to the carrier.

❒ (2) Copies of all documentation presented with the billing (reports, chart notes, diagnostic test results, treatment plans, etc.) , if any.

❒ (3) Copy of the Explanation of Review (EOR) from the payor, if received.

❒ (4) A summary of the requestor's position regarding the dispute. (Attach on a separate sheet.)

❒ (5) Proof of Service by Mail on all parties. (Attach on a separate sheet).

❒ (6) Copies of other communications between the provider and the payor regarding the dispute, if any.

⑦**For Your Information**

(1) Incomplete Requests will not be processed
(2) Respondents have 14 days from date of receipt to send in their position summary
(3) Review Recommendations will be served on the parties 30 days after receipt of Respondent's position summary

⑧**Signature of Requestor**

Signature Date

Draft 3/15/00

FOR OFFICE USE ONLY

Date Request Received: _____ Respondent called ❒ Yes ❒ No If yes, Date called: _____ Date Position Received: _____
❒ Documentation not enclosed: 1 2 3 4 5 6 ❒ Form incomplete ❒ No jurisdiction

Proof of Service By Mail

I declare that:

I am employed in the county of _____ California. I am over the age of eighteen years; my business address is:

_____

_____

_____

On _____, I served the attached Request for Medical Dispute Resolution on

_____ addressed as follows:
Name of Respondent

_____

_____

with the following enclosures:

_____

_____

_____

I declare under penalty of perjury under the laws of the State of California that the forgoing is true and correct, and that this declaration was executed on

_____, at _____ California.
Date Location

_____
Type or Print Name

_____
Signature